STATEMENT OF

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SUBMITTED TO THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

THE DEPARTMENT OF VETERANS AFFAIRS' EMERGENCY PREPAREDNESS ACT OF 2002 AND FORCE HEALTH PROTECTION FOR ACTIVE DUTY MILITARY FORCES

WASHINGTON, DC MARCH 27, 2003

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.6 million members of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, I would like to thank you for the opportunity to submit our views regarding the implementation of P.L. 107-287, *Department of Veterans Affairs Emergency Preparedness Act of 2002*, and efforts to coordinate force protection in the active duty military forces of the United States for those who may be exposed to chemical, biological, or radiological weapons of mass destruction in theaters of conflict.

Preventing a biological, chemical, or nuclear attack is of paramount importance to the security of the United States and to our troops stationed in the field. At the same time, if an attack were to occur, we must be prepared to handle it successfully.

Full implementation of P.L. 107-287 would move the Department of Veterans Affairs (VA) health care system, our nation's largest, one step closer towards total preparedness by establishing four medical emergency preparedness centers that would carry out research and

rapid response laboratory assistance into the detection, diagnosis, vaccination, protection, and treatment of chemical, biological, and radiological threats to the public health and safety. In addition, the Act requires the VA to develop and disseminate education and training programs on the medical responses to the consequences of terrorist activities, furnish health care during major disasters and medical emergencies, and expand the number of VA assistant secretaries to manage this new workload. The VFW was glad to lend its support for this legislation last Congress.

Unfortunately, and to the detriment of the nation, it is our understanding that this law has not been fully implemented. While the Act authorizes $20 million for each of the fiscal years 2003 through 2007 to establish the four centers, these funds were not made available by the appropriators. Further, the appropriators acknowledged the need for VA to participate in major disasters and medical emergencies while incongruously withholding funding to expand the number of assistant secretaries to manage preparedness activities. To ask VA to implement these sections of the Act with existing funds would be inappropriate and unconscionable given the current inability of VA to meet demand for veterans' health care. Congress should be mindful that situations such as this place VA in a Catch-22 position.

As for implementing the educational aspects of the Act, we understand that VA is disseminating information to its employees obtained from the Department of Defense (DOD) on the diagnosis and treatment of chemical, biological, and radiological exposures. However, until these centers of excellence are up and running it is unlikely that VA will possess the in-house expertise needed to develop and train public health care professionals to the degree required by the Act.

Finally, with respect to the codification of VA's authority to furnish health care in major disasters and medical emergencies, I would refer the subcommittee to our testimony of

October 11, 2001, before the full House Committee on Veterans' Affairs. While VA has certainly improved its inter-agency coordination since then, we feel that the actions taken by VA in the hours and days after the September 11, 2001, terrorists attacks exemplify what we would expect from VA today and in the future.

At this point, I would like to turn our attention to the issue of Force Health Protection (FHP). On January 24, 2002, we testified before this subcommittee that investigations conducted following the first Persian Gulf War pointed out that "'U.S. military forces were unprepared to fight a war in which chemical or biological weapons might be used' and 'both [DOD] and [VA] gave insufficient priority to matters of health protection, prevention, and monitoring of troops when they [were] on the battlefield and thereafter when they [became] veterans.' Further, and in our opinion, the most grievous finding was the failure of both agencies to 'collect information adequately about, keep good health records on, and produce reliable and valid data to monitor the health care and compensation status of Gulf War veterans' who were ill following their deployment to the Persian Gulf. As a result, basic research questions could not be answered; and thousands of Persian Gulf War veterans continue to suffer from undiagnosed illnesses."

Since the end of the Gulf War, the post-Cold War environment has witnessed frequent troop deployments. Each of these deployments possesses their own unique set of health care challenges and concerns. For example, DOD physicians report that the military member may experience physical or psychological trauma resulting from a variety of factors, such as combat, environmental extremes, illness or infectious disease, injury, weapons of mass destruction, and potential environmental threats.

In an attempt to address the mistakes of the past, as well as current deployment health concerns, DOD developed FHP. According to DOD, FHP "uses preventive health techniques and emerging technologies in environmental surveillance and combat medicine to protect all

service members before, during and after deployment. FHP is designed to improve the health of service members, prepare them for deployment, prevent casualties and promptly treat injuries or illnesses that do occur."

This proactive response has resulted in marked improvements in medical surveillance through the deployment of a interim theater medical information system that allows DOD to regularly and repeatedly collect, analyze, and disseminate uniform health information with respect to the battlefield. DOD has also made strides in the detection and protection against chemical and biological weapons by fielding an improved protective mask, a skin decontamination kit, an automatic injector for use against nerve agents, hand-held radiation detection devices, and the new chemical-biological suit--Joint Service Lightweight Integrated Suit Technology (JSLIST).

While DOD is to be commended for providing the best equipment and training in the world to our nation's soldiers, airmen, seamen, and marines, we remain concerned with the way in which they conduct baseline troop health assessments. Section 765 of P.L. 105-85 requires DOD to perform pre-deployment medical examinations and post-deployment medical examinations to include the drawing of blood. All of these exams are to be retained in a centralized location to improve future access.

Instead of fully implementing this law, DOD requires troops to *assess their own state of health* before and after deployments by filling out forms DD Form 2795, Pre-Deployment Health Assessment, and DD Form 2796, Post-Deployment Health Assessment. Further, this is supplemented through serum collection conducted during HIV testing within 12 months of deployment.

Self-assessment is, at best, questionable. For example, how is an infantryman expected to know if he has an infectious disease? He cannot possibly know. That is exactly why

P.L. 105-85 was enacted. Why take the chance of something going unreported or undetected when a physical examination and blood sample are more comprehensive and empirically sound? Until DOD fully implements P.L. 105-85, DOD and VA will not possess the valid data needed to answer basic research questions regarding the health status pre- and post-deployment of military members. Therefore, the potential to repeat the mistakes of the past are real.

The VFW believes that every veteran is entitled to a comprehensive career service member medical record of illnesses and injuries they suffer, the care and inoculations they receive, and their exposure to different hazards while stationed stateside and overseas. Further, the transfer of this health care record, coupled with the personnel file, from DOD to VA should be seamless because in order for VA to properly care for and compensate a veteran, it depends on accurate and timely information from the veteran's military health record.

In conclusion, we would again state our support for the full implementation of P.L.107-287, *Department of Veterans Affairs Emergency Preparedness Act of 2002* and Section 765 of P.L. 105-85.

Mr. Chairman, I thank you again for the opportunity to submit our views, and I will be happy to respond in writing to any questions you or members of the subcommittee may have.